



## Review Your Prescription

- ☒ Check to see if the patient name is clearly written on the prescription.
  - If not, print the patient's full name, address and phone number on the back of the prescription.
- ☒ Check to see if the doctor's signature is legible.
  - If not, circle the doctor's preprinted name on the prescription, or print the name of the doctor on the back of the prescription.
- ☒ Check to see if the doctor's phone number is printed on the prescription.
  - If not, print the doctor's phone number, including area code, on the back of the prescription.

## Review Your Order Form

Make sure you have completed the Allergies section. This enables our pharmacists to review your patient record before filling your prescription.

**HEARING IMPAIRED: XXX.XXX.XXXX**

**FOR REFILLS: [www.express-scripts.com](http://www.express-scripts.com)  
Toll-free, 866.DOD.TMOP (866.363.8667)**

## 2. SHIPPING INFORMATION

NOTE: You must provide a U.S. postal address.  
Prescriptions cannot be mailed to private foreign addresses.

First Name

Last Name

U.S. Postal Address, Including APO/FPO

City

State

ZIP Code

Phone #

## 3. PAYMENT INFORMATION

Standard delivery of your order is free. Your order will arrive within 10 days from the date you mail your order. To expedite shipping, you may choose to have your order sent by next-day delivery, after it is processed, for an additional charge.  
(NOTE: This will only affect shipping time, not the processing of your order.)

Please include payment with your order. **DO NOT SEND CASH.** To calculate your payment, refer to your *Beneficiary Guide* for your copayment.  
Add \$18 if you want next-day delivery.

Check/Money Order

Amount Enclosed: \$

Credit Card #:

Exp. Date:

Credit Card #:

Exp. Date:

NOTE: All future orders will be charged to one of these credit cards.

Card-Holder Name:

Please print name as it appears on card.

X

AUTHORIZED SIGNATURE

As required by the U.S. Department of Defense, we will dispense FDA-approved generic medications when allowed by your physician.

## 4. SIGNATURE INFORMATION

SIGNATURE REQUIRED →

X

SIGNATURE REQUIRED

IF APPLICABLE, PLEASE SIGN THE FOLLOWING STATEMENTS ONLY

I request that this and future orders be shipped "Signature Required." I understand there will be an additional charge for this service.

X

SIGNATURE REQUIRED

I would like my prescriptions dispensed in NON-child resistant caps.

X

SIGNATURE REQUIRED